OLR Bill Analysis

sSB 410 (File 283, as amended by Senate "A")*

AN ACT CONCERNING ADVERSE DETERMINATION REVIEWS.

SUMMARY:

This bill expands the information health insurance carriers must provide to covered persons or their authorized representatives, upon request, when they make an adverse determination (e.g., deny coverage), both in the initial determination and reviews of this determination. It requires carriers to provide copies of the information within one calendar or five business days of the request, depending on the circumstances of the case.

By law, health carriers must file annual reports with the insurance commissioner that include a certification that they are complying with the law's requirements regarding grievance procedures. The bill extends this provision to cover the requirements it adds. It requires the commissioner to adopt regulations regarding the provision of copies.

Health carriers must comply with the bill's provisions and implementing regulations and ensure that utilization review entities with whom they contract also do so.

The bill applies to any:

1. carrier offering a health benefit plan that provides or performs utilization review, including prospective, concurrent, or retrospective review benefit determinations; and

2. utilization review company or designee of a carrier that performs utilization review on the carrier's behalf, including prospective, concurrent, or retrospective review benefit determinations.

The bill does not apply self-insured plans covered by the federal

Employee Retirement Income Security Act (ERISA) or plans that provide health care services solely for workers' compensation benefits.

*Senate Amendment "A":

1. eliminates a provision that required carriers to provide certain information automatically, rather than upon request;

2. modifies the information carriers must provide; and

3. eliminates a provision that required a carrier to issue an electronic authorization to a covered person's pharmacy when he or she files a grievance or requests a review of an adverse or a final adverse determination relating to dispensing a drug, that would be valid for the duration of the grievance or review.

EFFECTIVE DATE: October 1, 2012

INITIAL DETERMINATION

By law, a carrier must promptly provide a covered person and, if applicable, his or her representative, with a notice of an adverse determination. The notice can be in writing or electronic. Under current law, the notice must state that the covered person or representative can receive, upon request, access to and copies of all documents, records, and other information relevant to the benefit request. The bill expands this requirement to include evidence and communications, and specifies that it applies to information regarding, rather than relevant to, the request. By law, the carrier must provide this information free of charge.

The bill requires that, at the request of the covered person or representative, the carrier provide him or her, free of charge, copies of all documents, communications, information and evidence, including citations to any medical journals, regarding the covered person's benefit request that is the subject of the adverse determination that (1) were not submitted by the covered person or his or her representative and (2) were available to the carrier or the utilization review entity that made the adverse determination when it was made.

The bill requires the carrier to provide the copies by fax, electronic means, or any other expeditious method within one calendar day after it receives a request in the case an adverse determination of an urgent care request. It requires the carrier to provide the copies within five business days after it receives a request in the case of an adverse determination of a non-urgent care request.

INTERNAL REVIEWS

Adverse Determinations Based on Medical Necessity

By law, carriers must review adverse determinations at the request of the covered person or his or her representative. In cases based in whole or part on medical necessity, before issuing a decision the carrier must provide the covered person or representative, free of charge, any new or additional (1) evidence relied upon and (2) scientific or clinical rationale the carrier used in connection with the grievance. The bill additionally requires the carrier to provide any related documents, communications, or information. It allows the carrier to provide the information required under current law and the bill by fax, electronic means, or any other expeditious method available.

By law, the carrier must notify the covered person and, if applicable, his or her representative of its decision following a review of its determination. Under current law, if the decision upholds the adverse determination, the notice must state that the covered person can receive, upon request, access to and copies of all documents, records, and other information relevant to the determination. The bill instead requires the notice to state that the covered person can obtain copies of all documents, records, communications, and other information regarding the adverse determination that were not previously provided to the covered person or representative. By law, the carrier must provide these copies free of charge.

The bill requires carriers, upon the request of the covered person or representative, to provide free of charge to him or her copies of all documents, communications, information, and evidence, including citations to any medical journals, if applicable, regarding the adverse

determination or the final adverse determination, as applicable, that were not (1) submitted by the covered person or his or her representative and (2) previously provided by the carrier.

The carrier must provide these copies by fax, electronic means, or any other expeditious method within five business days after the carrier receives a request regarding a final adverse determination of a prospective, concurrent, or retrospective review.

But the carrier must provide these copies using these methods within one calendar day after it receives a request regarding a final adverse determination regarding:

1. an expedited review request, an admission, availability of care, continued stay, or health care service for which the covered person received emergency services but has not been discharged from a facility;

2. a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that this care service or treatment would be significantly less effective if not promptly initiated; or

3. a medical condition for which the period for completing an expedited internal review of a grievance involving the adverse determination would seriously jeopardize the covered person's life or health or would jeopardize his or her ability to regain maximum function.

Adverse Determinations Based on Other Rationales

By law, carriers must establish procedures for reviewing grievances of adverse determinations that are not based on medical necessity and the review decision must refer to evidence or documentation used as the basis for the decision. The bill additionally requires the decision to refer to the relevant communications and information.

For decisions upholding an adverse determination, the bill also requires that the decision include a statement that the covered person may receive from the carrier, free of charge and upon request, reasonable access to and copies of, all documents, communications, information, and evidence regarding the subject of the final adverse determination.

Upon this request, the carrier must provide copies of the same information as described above with regard to determinations made on the basis of medical necessity. It must do so within five business days after it receives a request regarding a final adverse determination.

But the carrier must provide these copies using these methods within one calendar day after it receives a request regarding a final adverse determination regarding:

1. an admission, availability of care, continued stay, or health care service for which the covered person received emergency services but has not been discharged from a facility or

2. a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that this care service or treatment would be significantly less effective if not promptly initiated.

EXTERNAL REVIEWS

By law, when the carrier sends a notice of an adverse determination or final adverse determination, it must disclose that the covered person or representative can seek an external review. The bill requires the disclosure to state that the covered person or representative may request, free of charge, copies of all documents, communications, information, and evidence regarding the adverse determination or the final adverse determination that were not previously provided to him or her.

Upon this request, the carrier must provide copies of the same

information as described above with regard to determinations made on the basis of medical necessity. It must do by the deadlines described above for determinations based on rationales other than medical necessity.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 12 Nay 8 (03/20/2012)